CHARLES COUNTY

CLAIM COVER SHEET

(Claims may be sent in by mail or by fax)

To: **Kathy Anderson- AFLAC Representative** **Date: _____**

5825 Plank Rd.

Suite 113, PMB 201

Fredericksburg, VA 22407

FAX NUMBER: 540-548-2324

PHONE NUMBER: 540-548-3484

Employee's Name: _____

Employee ID Number _____

Employee Email address_____

Daytime Phone Number: _____

Number of Pages: _____

Brief Description of Claim: _____

_____

Patient's Name: _____

Relationship to Employee: [ ] Self [ ] Spouse [ ] Dependent Child

Accident Plan _____ **Critical Illness _____**

_____ Receipts are attached for Services

_____ Claim forms are attached